REISSUED 7/22/04

Highlighting indicates updates to memo

DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAL ASSISTANCE ADMINISTRATION
Olympia, Washington

To: EPSDT Clinics
Managed Care Plans

Memorandum No: 04-36 MAA
Reissued: July 22, 2004

From: Douglas Porter, Assistant Secretary
Medical Assistance Administration (MAA)

For Information Call:
1-800-562-6188

Supersedes: 03-29 MAA

Subject: Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Clinics: Fee Schedule and Billing Instruction Changes

Effective for dates of service on and after July 1, 2004, the Medical Assistance Administration (MAA) will:

- Implement the updated Medicare Physician Fee Schedule Data Base (MPFSDB) Year 2004 relative value units (RVUs);
- Implement the updated Medicare Clinical Laboratory Fee Schedule (MCLFS);
- Implement the updated Medicare Single Drug Pricer (SDP);
- Implement the Year 2004 additions of Current Procedural Terminology (CPT™) and Healthcare Common Procedure Coding System (HCPCS) codes; and
- Update various policies and billing instructions pages.

Maximum Allowable Fees

MAA is updating the EPSDT fee schedule with Year 2004 RVUs and clinical laboratory fees. The maximum allowable fees have been adjusted to reflect these changes. The 2004 Washington State Legislature **did not appropriate a vendor rate increase** for the 2005 state fiscal year.

EPSDT Interperiodic Screenings

MAA no longer reimburses providers for EPSDT interperiodic screenings. If a client is seen for a suspected health problem, providers must bill these services using the appropriate level Evaluation & Management (E&M) procedure code, with the ICD-9-CM diagnosis code that accurately describes the sign(s), symptom(s), or condition(s) found. **It is no longer necessary to bill with modifier EP for these services**.

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Billing Instructions Replacement Pages

Attached are replacement pages A1/A2; B1/B2; C1-C8; and E3-E10 for the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program Billing Instructions, dated July 2001. To obtain MAA's billing instructions and numbered memoranda electronically, go to MAA's website at http://maa.dshs.wa.gov (click on the Provider Publications/Fee Schedule link or the Billing Instructions/Numbered Memoranda link).

Bill MAA your usual and customary charge.

About the Program

What is the purpose of the EPSDT program?

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program is a federal preventive health care benefit. The purpose of this program is to screen clients 20 years of age and younger in order to identify physical and/or mental health problems. If a physical or mental health problem is identified, the client should be treated or referred to an appropriate provider for treatment. EPSDT is designed to encourage continuing access to health care.

Access to and services for EPSDT are governed by federal rules at 42 CFR, Part 441, Subpart B.

MAA's standard for coverage is that the services, treatment, or other measures must be:

- Medically necessary;
- Safe and effective; and
- Not experimental.

Who can provide EPSDT screenings?

- Physicians;
- Advanced Registered Nurse Practitioners (ARNPs);
- Physician Assistants (PAs);
- Nurses specially trained through the Department of Health (DOH); and
- Registered nurses working under the guidance of a physician or ARNP may also do EPSDT screenings. However, only physicians, PAs and ARNPs can diagnose and treat problems found in a screening.

> ☞ **Note:** DOH no longer provides training to nurses for EPSDT screenings.

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Client Eligibility

Who is eligible for EPSDT screenings?

MAA reimburses providers for EPSDT screenings provided to clients who:

- Are 20 years of age and younger; and
- Present a DSHS Medical ID card with one of the identifiers listed below:

Medical Program Identifier	Medical Program Name
CNP	Categorically Needy Program
CNP - CHIP	CNP - Children's Health Insurance Program
CNP - Emergency Medical Only	CNP - Emergency Medical Only (Covered only when the service is related to the emergent condition.)
LCP - MNP	Limited Casualty Program – Medically Needy Program

☞ **Note:** Please refer clients to their local Community Services Office (CSO) if they are 20 years of age and younger and their DSHS Medical ID card does not list one of the above medical program identifiers. The CSO will evaluate these clients for a possible change in their Medical Assistance program that would enable them to receive EPSDT screenings.

Are clients enrolled in a Healthy Options managed care plan eligible for EPSDT?

Yes! EPSDT screenings are included in the scope of service provided by MAA's managed care plans. Clients who are enrolled in one of MAA's managed care plans will have an identifier in the HMO column on their DSHS Medical ID card.

Please refer managed care clients to their respective managed care plan's primary care provider (PCP) for coordination of necessary preventive health care services and medical treatments, including EPSDT services. Clients can contact their plan by calling the telephone number indicated on their DSHS Medical ID card.

Do not bill MAA for EPSDT services as they are included in the managed health care plan's reimbursement rate.

Exception: MAA covers referrals for a mental health or substance abuse assessment outside the MAA managed care plan. These referrals are paid separately on a fee-for-service basis. Providers must bill MAA directly for these types of referrals.

Primary Care Case Management (PCCM):

For the client who has chosen to obtain care with a PCCM, the identifier in the HMO column will be "PCCM." These clients must obtain or be referred for services through the PCCM. The PCCM is responsible for coordination of care just like the Primary Care Provider (PCP) would be in a plan setting. Please refer to the client's DSHS Medical ID card for the PCCM.

> ☞ **Note:** To prevent billing denials, please check the client's DSHS Medical ID card prior to scheduling services and at the time of the service to make sure proper authorization or referral is obtained from the PCCM.

Billing for Infants Not Yet Assigned a Patient Identification Code (PIC)

Use the PIC of either parent for a newborn if the baby has not yet been issued a PIC. Enter indicator **B** in the comments section of the claim form to indicate that the baby is using a parent's PIC. When using a parent's PIC for twins or triplets, etc., identify each baby separately (i.e., twin A, twin B) using a *separate claim form* for each. **Note: The parents' Healthy Options Plan is responsible for providing medical coverage for the newborn.**

EPSDT Screening Components

What are EPSDT screenings?

EPSDT screenings are defined by federal rules as "regularly scheduled examinations and evaluations of the general physical and mental health, growth, development and nutritional status of infants, children and youth" that are provided as part of a health supervision program.

What is included in an EPSDT screening?

At a minimum, EPSDT screenings must include, but are not limited to:

- A comprehensive health and developmental history, updated at each screening examination;
- A comprehensive physical examination performed at each screening examination;
- Appropriate vision testing;
- Appropriate hearing testing;
- Developmental assessment;
- Nutritional assessment;
- Appropriate laboratory tests;
- Dental/oral health assessment, including:
  - ✓ How to clean teeth as they erupt.
  - ✓ How to prevent baby bottle tooth decay.
  - ✓ How to look for dental disease.
  - ✓ Information on how dental disease is contracted.
  - ✓ Preventive sealant.
  - ✓ Application of fluoride varnish, when appropriate.
- Health education and counseling; and
- Age appropriate mental health and substance abuse screening.

These components may be performed separately by licensed providers; however, MAA encourages the provider to perform as many of the components as possible to provide a comprehensive picture of the client's health.

Additional Screening Components:

For fee-for-service clients, the following screening services may be billed in addition to the EPSDT screening codes listed on the previous page:

- Appropriate audiometric tests (CPT® codes 92552 and 92553);
- Appropriate laboratory tests, including testing for anemia; and
- Appropriate testing for blood lead poisoning in children in high-risk environments (CPT codes 82135, 83655, 84202, and 84203).

How often should EPSDT screenings occur?

The following is Washington State's schedule for health screening visits:

- Five total screenings during the first year of the child's life. Below is a recommended screening schedule for children from birth to one year of age.
  - ✓ 1st Screening: Birth to 6 weeks old
  - ✓ 2nd Screening: 2 to 3 months old
  - ✓ 3rd Screening: 4 to 5 months old
  - ✓ 4th Screening: 6 to 7 months old
  - ✓ 5th Screening: 9 to 11 months old
- Three screening examinations are required between the ages of 1 and 2 years.
- One screening examination is required per 12-month period for children ages 2 through 6.
- One screening examination is required per 24-month period for children ages 7 through 20, except foster care clients, who receive a screening examination every 12 months and within 30 days of foster care placement or official relative placement through the Children's Administration.

Note: If a client is placed in foster care or is placed in the care of a relative, MAA reimburses providers for an EPSDT screen without regard to the periodicity schedule above.

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Foster Care Children

Foster care is defined as:

> Twenty-four hour per day temporary substitute care for a child placed away from the child's parents or guardians in licensed, paid, out-of-home care, and for whom the Department or a licensed or certified child placement agency has placement and care responsibility.

MAA reimburses providers an enhanced flat fee of $120.00 per EPSDT screening exam for foster care clients who receive their medical services through MAA's fee-for-service system. This applies to CPT codes 99381-99385 and 99391-99395 only.

To receive the enhanced rate, providers **must** bill the appropriate EPSDT code with modifier 21 in order to identify foster care clients.

MAA reimburses providers for an EPSDT screening exam for foster care clients without regard to the periodicity schedule when the screening exam is billed with modifier 21.

Note: A child placed outside of the home in the care of a relative does not qualify as a foster care client. However, MAA reimburses providers for an EPSDT screening exam without regard to the periodicity schedule for these clients using MAA's normal maximum allowable fee for EPSDT procedures. Providers must indicate "**EPSDT screen performed for child in relative care**" in the comments section of the claim form.

To receive the enhanced rate, providers are required to use either:

- The DSHS "Well Child Examination" forms for Infancy, Early Childhood, Late Childhood, and Adolescence [DSHS 13-683 A-E(x), 13-684 A-C(x), 13-685 A-C(x), and 13-686A-B(x)]; **or**
- Another charting tool with equivalent information.

To obtain copies of the Well Child Examination forms, use the form provided at the end of this section and write or fax:

> Medical Assistance Administration
> PO Box 45530
> Olympia, WA 98504-5530
> FAX (360) 753-7315

To download an electronic copy of the Well Child Examination form, go to:

http://www1.dshs.wa.gov/msa/forms/eforms.html

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What are the time limits for scheduling requests for EPSDT screenings?

Requests for EPSDT screenings must be scheduled within the following time limits:

If an EPSDT screening is requested through…	For client who are…	Must be scheduled within…
Managed Care plans, PCCM, or Primary Care Providers (PCPs)	Infants - within the first 2 years of life.	Within 21 days of request.
	Children – two years and older.	Within six weeks of request.
	Foster Care – Upon placement	Within 30 days of request, or sooner for children under 2 years.
Community Mental Health Center, Head Start, substance abuse provider, or Early Childhood Education and Assistance Program (ECEAP)	0 through 20 years of age	Within 14 days of the request.
Providers must ensure that when medically necessary services are identified during any EPSDT screening examination, appropriate treatment or referrals are made.		

EPSDT Interperiodic Screenings

☞ **Note:** MAA no longer reimburses providers for interperiodic screenings. If a client is seen for a suspected health problem, providers must bill these services using the appropriate level Evaluation & Management (E&M) procedure code, with the ICD-9-CM diagnosis code that accurately describes the sign(s), symptom(s), or condition(s) found. **It is no longer necessary to bill using modifier EP for these services**.

What if a medical problem is identified during a screening examination?

If a medical problem is identified during a screening examination, the provider may:

- Refer the client to an appropriate provider for medical treatment; or
- Provide the service for the client (if it is within the provider's scope of practice).

> ☞ **Note:** If the provider is using the parent's PIC code to bill E&M codes 99201-99215 for an infant who has not yet been assigned a PIC code, the provider must use modifier HA in order to be reimbursed at the higher rate for children's services. **Modifier HA must be the first modifier following the CPT or HCPCS code**. Any additional modifier may be listed second.

If the provider chooses to treat the medical condition on the same day as the screening exam, the provider must bill the appropriate level E&M code with modifier 25 in order to receive additional reimbursement for the office visit. Providers must bill using the appropriate ICD-9-CM medical diagnosis code that describes the condition found. **The E&M code and the EPSDT screening procedure code must be billed on separate claim forms.**

Referrals

Chiropractic Services
Eligible clients may receive chiropractic services when a medical need for the services is identified through an EPSDT screening. Use the usual professional referral procedures (e.g., a prescription or letter) to refer clients for medically necessary chiropractic services.

Dental Services
Eligible clients may go to a dental provider without an EPSDT screen or referral.

Orthodontics
Eligible clients may go to an orthodontic provider without an EPSDT screen or referral. MAA reimburses for orthodontics for children with cleft lip or palates or severe handicapping malocclusions only. MAA does not reimburse for orthodontic treatment for other conditions.

Lead Toxicity Screening
Providers are no longer required to use the Lead Toxicity Screening Risk Factor questionnaire. Health care providers should use clinical judgment when screening for lead toxicity.

Fetal Alcohol Syndrome (FAS) Screening
FAS is a permanent birth defect syndrome caused by the mother's consumption of alcohol during pregnancy. FAS is characterized by cognitive/behavioral dysfunction caused by structural and/or chemical alterations of the brain, a unique cluster of minor facial anomalies, and is often accompanied by growth deficiency.

As part of the EPSDT screen every child six months of age and older should be screened for risk of exposure to maternal consumption of alcohol and for the facial characteristics of FAS. Children can be referred to a diagnostic clinic if there is known in-utero exposure to alcohol, or there is suspicion of facial characteristics of FAS or microcephaly.

Washington State
Fetal Alcohol Syndrome (FAS)
Clinic Locations

King County (Univ. of WA)

Who to Contact:
Susan Astely, Ph.D. or
Sterling Clarren, M.D. Co-Directors
Children's Hospital and Regional Medical Center
4800 Sand Point Way NE, CH-47
Seattle, WA 98105
(206) 526-2522
http://depts.washington.edu/fasdpn/wasites.html
(206) 527-3959 FAX

Clinic Location:
FAS DPN Clinic
Center on Human Development and Disability
University of Washington
Seattle, WA 98195

South King County (Federal Way)

Who to Contact:
Donna Borgford-Parnell, RN, BSN, MBA
(206) 296-7412
(206) 296-4679 FAX

Clinic Location:
FAS DPN Clinic
Federal Way Public Health Clinic
Seattle King County Department of Health
999 – 3rd Avenue, Suite 900
Seattle, WA 98104
Donna.Borgford-Parnell@metrokc.gov

Snohomish County (Everett)

Who to Contact:
Christie Conners, Clinic Coordinator
(425) 870-4749
(425) 513-0917 FAX

Clinic Location:
FAS DPN Clinic
Little Red Schoolhouse
14 E. Casino Rd.
Everett, WA 98208

Spokane County (Spokane)

Who to Contact:
Teryl MacDonald, Clinic Coordinator
(509) 624-5858 ext. 22
(509) 624-9995 FAX

Clinic Location:
FAS DPN Clinic
New Horizons
504 E. 2nd Avenue
Spokane, WA 99202
tmacdonald@srhd.org
www.spokanecounty.org/health/sms

Yakima County (Yakima)

Who to Contact:
JoAnn Jennings, RN, Clinic Coordinator
(509) 574-3260
(509) 574-3210 FAX

Clinic Location:
FAS DPN Clinic
Children's Village
3801 Kern Road
Yakima, WA 98902
JoAnn.Jennings@yvmh.org

Medical Nutrition Therapy

If an EPSDT screening provider suspects or establishes a medical need for medical nutrition therapy, eligible clients may be referred to a certified dietitian to receive outpatient medical nutrition therapy. Use the usual professional referral procedures (e.g., a prescription or letter) to refer clients for medically necessary medical nutrition therapy.

MAA reimburses the procedure codes listed below when referred by an EPSDT provider. **Providers must document beginning and ending times that the service was provided in the client's medical record.**

Procedure Code	Brief Description	Limitations
97802	Medical nutrition, indiv, initial	1 unit = 15 minutes; maximum of 2 hours (8 units) per year
97803	Med nutrition, indiv, subseq	1 unti = 15 minutes; maximum of 1 hour (4 units) per day
97804	Medical nutrition, group	1 unit = 15 minutes; maximum of 1 hour (4 units) per day

Fluoride Varnish (HCPCS code D1203)

Fluoride varnish is a type of topical fluoride that acts to retard, arrest, and reverse the caries process. It is applied up to three times per year to all surfaces of the teeth. The teeth then absorb the fluoride varnish, strengthening the enamel and helping prevent cavities.

Who must prescribe the fluoride varnish?

- Dentists;
- Physicians;
- Physician Assistants (PA); or
- Advanced Registered Nurse Practitioners (ARNP).

Who is eligible?

All Medicaid-eligible clients, 18 years of age and younger, may receive fluoride varnish applications. Department of Developmental Disabilities (DDD) clients age 19 and older are also eligible.

Are managed care clients eligible?

Clients whose DSHS Medical ID cards have an identifier in the HMO column are enrolled in one of MAA's managed health care plans. These clients **are eligible for fluoride varnish applications** through fee-for-service. Bill MAA directly for fluoride varnish applications.

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Synagis (CPT code 90378)

- Bill one unit for each 50 mg of Synagis used.
- MAA covers Synagis for those clients ages 11 months and younger from December 1-April 30 of any given year without prior authorization (PA).
- PA is required for all other time periods and for all other age groups.

Requests for authorization must be submitted in writing to:

MAA-Division of Medical Management
Attn: Synagis Program
PO Box 45506
Olympia, WA 98504-5506
FAX: (360) 725-2141

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Third party liability

You must bill the insurance carrier(s) indicated on the client's MAID card. An insurance carrier's time limit for claim submissions may be different than MAA's. It is your responsibility to meet the insurance carrier's requirements relating to billing time limits, as well as MAA's, prior to any payment by MAA.

You must meet MAA's 365-day billing time limit even if you haven't received notification of action from the insurance carrier. If your claim is denied due to any existing third-party liability, refer to the corresponding MAA *Remittance and Status Report* for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by MAA, or if you have reason to believe that MAA may make an additional payment:

- Submit a completed claim form to MAA; and
- Attach the insurance carrier's statement.

If you are rebilling, also attach a copy of the MAA *Remittance and Status Report* showing the previous denial.

If you are rebilling electronically, list the Internal Control Number (ICN) of the previous denial in the **Comments** field of the Electronic Media Claim (EMC).

Third-party carrier codes are available via the Internet at http://maa.dshs.wa.gov or by calling the Coordination of Benefits Section at 1-800-562-6136.

Fee Schedule

EPSDT Screenings

Note: Make certain the procedure code you use corresponds correctly to the age of the child receiving the EPSDT services.

Due to its licensing agreement with the American Medical Association, MAA publishes only the official, brief CPT procedure code descriptions. To view the full descriptions, refer to your current CPT book.

New Patient

Procedure Code	Brief Description	7/1/04 Maximum Allowable Fee		
		NFS Fee	FS Fee	Foster Care*
99381	Prev visit, new, infant	$75.65	$46.48	$120.00
99382	Prev visit, new, age 1-4	83.67	54.55	120.00
99383	Prev visit, new, age 5-11	87.07	57.95	120.00
99384	Prev visit new, age 12-17	93.56	64.74	120.00
99385	Prev visit, new, age 18-20	95.77	66.28	120.00

Established Patient

Procedure Code	Brief Description	7/1/04 Maximum Allowable Fee		
		NFS Fee	FS Fee	Foster Care*
99391	Prev visit, est. infant	$57.75	$40.25	$120.00
99392	Prev visit, est, age 1-4	66.29	48.28	120.00
99393	Prev visit, est, age 5-11	69.98	51.64	120.00
99394	Prev visit, est, age 12-17	76.65	58.00	120.00
99395	Prev visit, est, age 18-20	79.38	59.38	120.00

*Providers must bill the appropriate screening code with modifier 21 in order to receive the enhanced rate for foster care children.

☞ **Note:** A child placed by Children's Administration outside of the home in the care of a relative does not qualify as a foster care client. However, MAA reimburses providers for an EPSDT screening exam without regard to the periodicity schedule for these clients using MAA's normal maximum allowable fee for EPSDT procedures. Providers must indicate "**EPSDT screen performed for child in relative care**" in the comments section of the claim form.

The appropriate diagnosis code is required when billing the above EPSDT screening CPT codes 99381-99395 (e.g., V20.2).

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Laboratory Services

Procedure Code	Brief Description	7/1/04 Maximum Allowable Fee	
		NFS Fee	FS Fee
36415	Drawing blood	$2.45	$2.45
81000	Urinalysis, nonauto w/scope	3.53	3.53
81001	Urinalysis, auto w/scope	3.53	3.53
81002	Urinalysis, nonauto w/o scope	2.85	2.85
81003	Urinalysis, auto, w/o scope	2.50	2.50
81005	Urinalysis	2.41	2.41
81007	Urine screen for bacteria	2.86	2.86
81015	Microscopic exam of urine	3.38	3.38
81025	Urine pregnancy test	4.18	4.18
81050	Urinalysis, volume measure	3.34	3.34
81099	Urinalysis test procedure	By report	By report
82135	Assay, aminolevulinic acid	18.33	18.33
83655	Assay of lead	13.48	13.48
84035	Assay of phenylketones	2.34	2.34
84202	Assay RBC protoporphyrin	15.98	15.98
84203	Test RBC protoporphyrin	9.56	9.56
85013	Hematocrit	2.64	2.64
85014	Hematocrit	2.64	2.64
85018	Hemoglobin	2.64	2.64
86580	TB intradermal test	6.35	6.35
86585	TB tine test	4.99	4.99

Immunizations

Immunizations for EPSDT are usually given in conjunction with a screening exam. Do not bill an Evaluation and Management (E&M) code unless there is a separate, identifiable diagnosis that is different from the immunization.

Immunizations covered under the EPSDT program are listed in the vaccine table on page E.10. Those vaccines that are shaded in the table are available at no cost from the Department of Health (DOH) through the Universal Vaccine Distribution program and the Federal Vaccines for Children program for children 18 years of age and under. MAA does not reimburse providers for these vaccines.

Providers must bill for the administration of the vaccine and for the cost of the vaccine itself as detailed on the following page:

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Clients 18 year of age and under – Shaded Vaccines

- These vaccines are available at no cost from DOH. Therefore, MAA reimburses providers for an administration only.

- Bill for the administration by reporting the procedure code for the vaccine given with modifier SL (e.g. 90707 SL).

- DO NOT bill CPT codes 90471 or 90472 for the administration.

Clients 18 year of age and under – Non-shaded Vaccines

- Bill MAA for the cost of the vaccine itself by reporting the procedure code for the vaccine given. DO NOT use modifier SL with non-shaded vaccines. MAA reimburses providers for the vaccine using MAA's maximum allowable fee schedule.

- Bill for the administration using CPT codes 90471 (one vaccine) and 90472 (each additional vaccine). Reimbursement is limited to one unit of 90471 and one unit of 90472 (maximum of two vaccines).

- Providers **must** bill 90471 and 90472 on the **same** claim as the procedure code for the vaccine.

Clients 19-20 years of age – All Vaccines

- Bill MAA for the cost of the vaccine itself by reporting the procedure code for the vaccine given. DO NOT use modifier SL with any of the vaccines for clients 19-20 years of age, regardless of whether the vaccine is shaded or not. MAA reimburses providers for the vaccine using MAA's maximum allowable fee schedule.

- Bill for the administration using CPT codes 90471 (one vaccine) and 90472 (each additional vaccine). Reimbursement is limited to one unit of 90471 and one unit of 90472 (maximum of two vaccines).

- Providers **must** bill 90471 and 90472 on the **same** claim as the procedure code for the vaccine.

Note: Only Health Departments may bill CPT code 99211 when an immunization is the only service provided.

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Procedure Code	Brief Description	7/1/04 Maximum Allowable Fee	
		NFS Fee	FS Fee
90471	Immunization admin	$5.00	$5.00
90472	Immunization admin, each add	3.00	3.00

Immunization Fees

Procedure Code	Brief Description	7/1/04 Maximum Allowable Fee	
		NFS Fee	FS Fee
90585	Bcg vaccine, percut	$143.28	$143.28
90586	Bcg vaccine, intravesical	151.49	151.49
90632	Hep a vaccine, adult im	62.94	62.94
90633	Hep a vacc, ped/adol, 2 dose	26.66	26.66
90636	Hep a/hep b vacc, adult im	83.33	83.33
90646	Hib vaccine, prp-d, im	36.82	36.82
90647	Hib vaccine, prp-omp, im	23.25	23.25
90648	Hib vaccine, prp-t, im	21.78	21.78
90655	Flu vacc split pres free 6-35 months	12.90	12.90
90656	Flu vacc split pres free 3 years and up	9.00	9.00
90657	Flu vaccine, 6-35 mo, im	3.10	3.10
90658	Flu vaccine, 3 yrs, im	9.00	9.00
90660	Flu vaccine, nasal	Not Covered	Not Covered
90665	Lyme disease vaccine, im	49.23	49.23
90669	Pneumococcal vacc, ped<5	65.47	65.47
90675	Rabies vaccine, im	121.83	121.83
90676	Rabies vaccine, id	67.04	67.04
90690	Typhoid vaccine, oral	36.84	36.84
90691	Typhoid vaccine, im	37.58	37.58
90692	Typhoid vaccine, h-p, sc/id	2.07	2.07
90700	Dtap vaccine, im	20.05	20.05
90701	Dtp vaccine, im	18.21	18.21
90702	Dt vaccine <7, im	4.60	4.60
90703	Tetanus vaccine, im	12.86	12.86
90704	Mumps vaccine, sc	17.38	17.38
90705	Measles vaccine, sc	13.45	13.45
90706	Rubella vaccine, sc	14.97	14.97
90707	Mmr vaccine, sc	34.93	34.93
90708	Measles-rubella vaccine, sc	21.81	21.81
90712	Oral poliovirus vaccine	17.59	17.59
90713	Polovirus vaccine	23.00	23.00
90715	TdaP, 7 years & older, intramuscular	Acquisition cost	Acquisition cost
90716	Chicken Pox vaccine, sc	57.86	57.86

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Procedure Code	Brief Description	7/1/04 Maximum Allowable Fee	
		NFS Fee	FS Fee
90717	Yellow fever vaccine, sc	52.93	52.93
90718	Td vaccine >7, im	10.31	10.31
90720	Dtp/hib vaccine, im	33.63	33.63
90725	Cholera vaccine, injectable	2.78	2.78
90732	Pneumoccocal vacc, adult/ill (*requires prior authorization)*	16.85	16.85
90733	Meningococcal vaccine, sc	$58.66	$58.66
90734	Meningococcal vaccine, intramuscular (*requires prior authorization*)	Acquisition cost	Acquisition cost
90735	Encephalitis vaccine, sc	71.37	71.37
90740	Hepb vacc, ill pat 3 dose im	100.41	100.41
90743	Heb b vacc, adol, 2 dose, im	24.49	24.49
90744	Hepb vacc ped/adol 3 dose, im	24.49	24.49
90746	Hep b vaccine, adult, im	50.21	50.21
90747	Hepb vacc, ill pat 4 dose, im	100.41	100.41
90748	Heb b/hib vaccine, im	92.02	92.02
90749	Vaccine toxoid	Not Covered	Not Covered

Drugs Administered in the Provider's Office

Procedure Code	Brief Description	7/1/04 Maximum Allowable Fee	
		NFS Fee	FS Fee
J0850	Cytomegalovirus imm IV / vial	$637.12	$637.12
J1460	Gamma globulin 1 CC inj	10.20	10.20
J1470	Gamma globulin 2 CC inj	20.40	20.40
J1480	Gamma globulin 3 CC inj	30.63	30.63
J1490	Gamma globulin 4 CC inj	40.80	40.80
J1500	Gamma globulin 5 CC inj	51.00	51.00
J1510	Gamma globulin 6 CC inj	61.08	61.08
J1520	Gamma globulin 7 CC inj	71.33	71.33
J1530	Gamma globulin 8 CC inj	81.60	81.60
J1540	Gamma globulin 9 CC inj	91.89	91.89
J1550	Gamma globulin 10 CC inj	102.00	102.00
J1560	Gamma globulin > 10 CC inj (per cc)	16.02	16.02
J1563	IV immune globulin	66.00	66.00
J1564	Immune globulin 10 mg	0.72	0.72

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Procedure Code	Brief Description	7/1/04 Maximum Allowable Fee	
		NFS Fee	FS Fee
J1565	RSV-ivig	$14.81	$14.81
J1670	Tetanus immune globulin inj	106.25	106.25
J2790	Rho d immune globulin inj	89.76	89.76
J2792	Rho(D) immune globulin h, sd	18.39	18.39
90780	IV infusion therapy, 1 hour	54.41	54.41
90781	IV infusion, additional hour	15.19	15.19
90782	Injection, sc, im	11.34	11.34
90783	Injection, ia	11.56	11.56
90784	Injection, iv	22.90	22.90

Immune Globulins

Procedure Code	Brief Description	7/1/04 Maximum Allowable Fee	
		NFS Fee	FS Fee
90281	Human ig, im	Not covered	Not covered
90283	Human ig, iv	Not covered	Not covered
90287	Botulinum antitoxin	Not covered	Not covered
90288	Botulism ig, iv	Not covered	Not covered
90291	Cmv ig, iv	Not covered	Not covered
90296	Diphtheria antitoxin	Not covered	Not covered
90371	Hep b ig, im	$116.28	$116.28
90375	Rabies ig, im/sc	65.18	65.18
90376	Rabies ig, heat treated	69.89	69.89
90378	Rsv ig, im, 50 mg ***May require prior authorization (refer to page C.8)***	597.35	597.35
90379	Rsv ig, iv	Not covered	Not covered
90384	Rh ig, full-dose, im	Not covered	Not covered
90385	Rh ig, minidose, im	Not covered	Not covered
90386	Rh ig, iv	Not covered	Not covered
90389	Tetanus ig, im	Not covered	Not covered
90393	Vaccina ig, im	Not covered	Not covered
90396	Varicella-zoster ig, im	96.32	96.32
90399	Immune globulin	Not covered	Not covered

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Audiologic Function Tests

The audiometric tests listed below imply the use of calibrated electronic equipment. Other hearing tests are considered part of the general otorhinolaryngologic services and are not billed separately.

Procedure Code	Brief Description	7/1/04 Maximum Allowable Fee	
		NFS Fee	FS Fee
92552	Pure tone audiometry, air	$10.88	$10.88
92553	Audiometry, air & bone	16.32	16.32

Fluoride Varnish Applications

Procedure Code	Brief Description	7/1/04 Maximum Allowable Fee	
		NFS Fee	FS Fee
D1203	Topical fluor w/o prophy chi	$13.39	$13.39

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